

2012 BENEFITS GUIDE

FOR COVERAGE EFFECTIVE JANUARY 1, 2012

HEALTH BENEFITS INFORMATION FOR RETIREES OF PACIFIC NORTHWEST NATIONAL LABORATORY

- Non-Medicare Eligible
- Medicare Eligible
- LTD > 2 Years

Inside the 2012 Benefits Guide

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Many key benefits terms, such as “co-payment” and “co-insurance,” are defined in the glossary at the end of this guide.

Important Notice of Summarized Information:

This summary outlines the features of several benefits plans available to eligible retirees. While we have attempted to describe the benefits as accurately as possible, due to the relatively brief nature of this summary and the complexity of the plans that govern these benefits, some details may not be described or may be described only briefly. Consequently, any conflicts between this summary and the actual legal plan document will be controlled by the terms of the legal plan document, not this summary. Likewise, any confusion about the plans that arise from reading this summary should be resolved by referring to the actual legal plan document. Battelle reserves the right to amend the plans at its discretion.

Welcome to Your 2012 Benefits

Each fall, we focus on our benefits for the coming year. This guide provides an overview of the medical and dental benefits offered to you by PNNL. Please take time to read this booklet and keep it as a reference all year.

If you want to keep the same coverage that you already have, you do not need take any action. You will be automatically enrolled in benefits based on your 2011 coverage.

There are no changes to your benefits coverage for 2012, however rates have increased and can be found on the Benefits Rates sheet accompanying this guide.

We're Here to Help

We are committed to helping you understand the total value of your retiree health benefits. Throughout this booklet, we have outlined many resources for you to learn more about your benefit plans.

In addition to these resources, *we are here to help*. Please see the **“When and How to Contact PNNL”** section of this booklet for additional information.

PNNL Benefits Office
Pacific Northwest National Laboratory
902 Battelle Boulevard
P.O. Box 999, MS K1-34
Richland, WA 99352
(509) 375-6361
<http://benefits.pnnl.gov/retirees.stm>
ask.benefits@pnnl.gov

Important Anthem Information for All Retiree Medical Plan Enrollees

Please refer to the Retiree Medical Plan Summary for detailed information about your medical coverage.

Find Your Doctor

To determine if your doctor is in the Anthem network, visit www.anthem.com, go to “Find a Doctor” and follow the steps on the screen. If you choose “Advanced Search,” you can enter the alpha prefix BZM for the Retiree Network Only Plan or BTK for the Retiree Medicare Complement Plan under the “Your Insurance” section. This will allow you to search for doctors within your plan.

Ask a Nurse

When you have general health questions or need guidance for critical health concerns, call the Anthem 24-Hour Nurse Line at (888) 596-9473 to speak confidentially to an experienced registered nurse.

Manage Your Medical Plan Online

In addition to searching for providers, registering on Anthem’s website also provides you with the ability to access your claims and payment information, request a new ID card and view tools to help you make health management decisions. When on Anthem’s homepage, choose “Register” under “Member Log In.” Enter your personal information, including your Member ID Number found on your ID card. For security reasons, you will also be asked to put in the security code that is shown. Click “Save & Continue” and enter a username and password, choose your notification preferences and confirm your registration. Helpful hints are given throughout your registration to help you finish each step. Look for them on the right-hand side of your computer screen.

Please be aware, if you wish to view information for your spouse and/or children who are older than 18, you must ask them to assign you viewing rights to their medical plans through Anthem’s website.

Your Quick Reference Guide to Anthem

Anthem Customer Service 8 a.m. – 7 p.m. EST Monday – Friday	(800) 514-3021
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Anthem 24-Hour Nurse Line 24 hours a day, 7 days a week	(888) 596-9473
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Anthem Website 24 hours a day, 7 days a week	www.anthem.com
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Vision Coverage

Anthem Blue View Vision Plan

If you are enrolled in Battelle’s Network Only Medical Plan for Retirees not eligible for Medicare, you will automatically receive exam coverage under the Anthem medical plan. You must use an in-network vision exam provider in order for the exam to be covered. Your vision hardware will be covered under a separate plan, the Anthem Blue View Vision Plan. While you can use a non-network provider for vision hardware, your benefits under the plan will be greater if your provider is part of the Anthem Blue View Vision network. **Please refer to the Retiree Medical Plan Summary for additional information about your vision coverage.**

How to Search for a Network Vision Exam Provider

Visit www.anthem.com, then:

- Click on “Find A Doctor”
- Under “What are you looking for?” click on Doctor & Other Health Professional
- Then on the next drop down, you need to click on “Vision Specialists”
- Enter your location information

How to Search for a Network Vision Hardware Provider

Visit www.anthem.com, then:

- Click on “Find A Doctor”
- Under “What are you looking for?” you will need to click on **Vision**
- Select to search by “Vision Doctors/Optometrists” or “Facilities”

Frequency of Services (based on a rolling timeline, not per calendar year)

- Vision Exam - 12 months
- Lenses - 12 months
- Frames - 24 months
- Contact Lenses - 12 months

Filing Your Claim

An in-network provider will file the claim on your behalf. If you visit an out-of-network vision hardware provider, you will need to obtain, complete and submit a claim form. You can find the form at <http://benefits.pnnl.gov/retirees.stm>.

Manage Your Vision Plan Online

In addition to searching for providers, registering on Anthem’s website at www.anthem.com also provides you with the ability to access your vision claims information.

Your Quick Reference to Anthem Blue View Vision

Anthem Blue View Vision Plan Customer Service
(866) 723-0515 8 a.m. – 7 p.m. Monday - Friday
www.anthem.com

Prescription Drug Benefits – All Retiree Medical Plans

Having a prescription drug benefit helps manage the cost of your prescription needs. Regardless of which medical plan you are enrolled in, your prescription drug coverage will be administered by CVS Caremark. There are four components to your prescription drug program:

CVS Caremark Retail Program

When filling prescriptions for short-term, acute care medications, such as antibiotics, and when filling a new prescription for a new therapy, it is important that you use a participating retail network pharmacy to receive your full plan benefit. Most large chain and local retail pharmacies are part of the CVS Caremark retail network, including more than 64,000 participating pharmacies nationwide, such as CVS, Walgreens, Fred Meyer and others.

CVS Caremark Mail Order Program

The CVS Caremark Mail Order Program is a cost-effective and convenient choice for long-term medications. You will receive up to a 90-day supply delivered right to your door for a lower cost than you would pay for three 30-day fills at a retail pharmacy. Mail order is required for all maintenance medications, or you can get a 90-day supply at your local CVS pharmacy.

CVS Caremark Specialty Pharmacy Services

The CVS Caremark Specialty Pharmacy is designed for individuals who take medications for certain chronic or genetic conditions. If your medication qualifies for Specialty Pharmacy Services, CVS Caremark will notify you at the time you fill your specialty prescription. This benefit offers convenient delivery of your specialty medicines, personalized service, and educational support for your specific therapy. CVS Caremark assigns a team of professionals to help you successfully manage your condition and improve your quality of life. This service includes 24-hour phone access to a clinical pharmacist for consultation at no additional cost to you.

Specialty drugs will continue to be filled through the Specialty Pharmacy Mail Order for a 30-day supply. The co-payment will remain \$80 per 30-day supply.

CVS Caremark Value Generic Program

A select list of more than 100 generic medications called the Value Generic Drug List is available at a reduced co-payment amount of \$3.33 for a 30-day supply at any retail pharmacy in the Caremark national network, and \$9.99 for a 90-day supply through mail order or obtained at the local CVS pharmacy. The list of drugs available on this program is comparable to those on other retailers' special programs, will be updated quarterly by Caremark and posted on www.caremark.com

For 2012, the co-payment will remain for all generic and specialty drugs, and cost-sharing for formulary and non-formulary drugs continues to be structured as a co-insurance percentage of the prescription's cost, with minimums and maximums. **Please refer to the Retiree Medical Plan Summary for additional information about your prescription drug coverage.**

How Much Will Your Medicine Cost?

Your cost for formulary and non-formulary drugs is determined by a co-insurance percentage. For instance, if you fill a prescription for a 30-day supply of a formulary drug and the cost of it is \$168, you would pay 30 percent of the total which is \$50.40.

If the actual cost of the drug is less than the minimum co-payment amount, you will always pay the actual cost of the drug. So, if you fill a prescription for a 30-day supply of a formulary drug and the cost of it is \$48 and the minimum co-payment is \$50, you would only pay \$48.

To determine the cost of your medications, you can log in to www.caremark.com, click on the "Understand My Plan and Benefits" tab and enter your medication(s). If you are not registered on Caremark's site, the drug cost calculator is also available on www.caremark.com/battelle/, Caremark's customized site for Battelle plan participants.

Additional Resources

Go to Battelle's Benefits internet site <http://benefits.pnnl.gov/retirees.stm> or www.caremark.com/battelle for more information on:

- Maintenance Medications drug list and benefits
- Prior authorization process and the list of drugs that require prior authorization
- List of medications that do not qualify for benefits because there is an exact over-the-counter equivalent
- Formulary drug list, also called the Performance Drug List or "PDL" by Caremark
- Value Generics list

Your Quick Reference Guide to CVS Caremark

Please use the resources below to find out more about filling your prescription through the retail pharmacy or the mail order program.

PNNL Dedicated Customer Service Toll-Free Phone Line
(877) 668-8993
24 hours a day, 7 days a week

CVS Caremark's Website
www.caremark.com

Pre-Enrollment Website
www.caremark.com/battelle

Dental Plan

Delta Dental PPO Plan

If you are enrolled in the dental plan, you are covered under Delta Dental PPO, a preferred provider organization (PPO) program. *Delta Dental PPO provides you with access to two of the nation's largest networks of participating dentists: the Delta Dental PPO Network and the Delta Dental Premier Network.* Delta Dental PPO offers the widest selection of participating dentists available anywhere.

You are free to go to any licensed dentist, regardless of whether that dentist participates in the Delta Dental programs. However, you are likely to save money and time by going to a dentist who participates in one of the two Delta Dental networks where the participating dentists submit the claim forms for you. If you go to a dentist who does not participate in the Delta Dental PPO or Delta Dental Premier Network, you will still have benefits. Covered services will be paid according to the Plan of Benefits outlined below. You will need to pay your dentist and submit your claim yourself. Delta Dental will reimburse you for the amount covered by the plan.

Find Your Dentist

If you would like the names of participating dentists near you, call Delta Dental's toll-free Customer Service department at (800) 524-0149. You can also access the dentist directory on their website at www.deltadentaloh.com.

To find in-network dentists:

- Click "Enrollees" on the left hand side of the page
- Under "Enrollees," click "Find a Provider"
- Click "Delta Dental"
- Select "Delta Dental PPO" or "Delta Dental Premier"
- You can search by provider name, location, or specialty

When you search for dental providers, you can search the Delta Dental PPO Network or the Delta Dental Premier Network. Both the PPO and Premier Network providers will submit claims for you, and cannot bill you for any amount over the Delta fee schedule. You may experience greater cost savings by selecting a PPO dental provider since their negotiated fees are lower than the fees for the Premier providers. Please see the chart for more information.

Membership Cards

Although you do not need to show your identification cards to your dentist to receive benefits for dental treatment, you may wish to carry the cards with you for informational purposes since Delta Dental's toll-free telephone number and website are printed on the cards. You can also register on www.deltadentaloh.com and print identification cards.

To register on Delta’s website:

- Click on “Enrollees” on the left-hand side of the page
- Select “Consumer Toolkit”
- Select the link to register

The Difference Between Network and Non-participating Dentists

	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Non-participating Dentist
What is the payment based on?	The billed fee or the amount in your dentist local PPO Fee Schedule, whichever is less	The billed fee or the Maximum Approved Fee, whichever is less	The billed fee or the Non-participating Dentist Fee, whichever is less
Payment example of a Class II dental benefit (assuming deductible has been met)	<p>Billed charges: \$100</p> <p>PPO Fee Schedule amount: \$76</p> <p>Delta Pays 80% of the PPO fee schedule: \$60.80</p> <p>Member Pays: \$15.20</p> <p>The PPO dentist cannot charge you the \$24 difference between the PPO Fees Schedule amount and his/her fee</p>	<p>Billed charges: \$100</p> <p>Maximum Approved Fee: \$92</p> <p>Delta Pays 80% of the Maximum Approved Fee: \$73.60</p> <p>Member Pays: \$18.40</p> <p>The Premier dentist cannot charge you the \$8 difference between the Maximum Approved Fee and his /her fee</p>	<p>Billed charges: \$100</p> <p>Non-participating Dentist Fee: \$93</p> <p>Delta Pays 80% of the Non-participating Dentist Fee: \$74.40</p> <p>Member Pays: \$25.60</p> <p>Because the dentist does not participate, you are responsible for the difference between Delta’s payment and his/her fee.</p>

Your Dental Plan Services and Coverage through Delta Dental of Ohio

	PPO Dentist	Premier Dentist	Nonparticipating Dentist*
	Plan Pays	Plan Pays	Plan Pays
Class I Benefits			
Diagnostic and Preventive Services - includes exams, cleanings, fluoride, and space maintainers		100%	
Emergency Palliative Treatment - to temporarily relieve pain		100%	
Brush Biopsy - to detect oral cancer		100%	
Radiographs - X-rays		100%	
Deductible	\$50 for individual / \$150 for family		
Class II Benefits			
Minor Restorative Services - includes fillings		80%	
Periodontic Services - to treat gum disease		80%	
Endodontic Services - includes root canals		80%	
Oral Surgery Services - extractions and dental surgery		80%	
Other Basic Services - misc. services		80%	
Class III Benefits			
Relines and Repairs - to bridges and dentures		50%	
Major Restorative Services - includes crowns		50%	
Prosthodontic Services - includes bridges and dentures		50%	
Implants - endosteal implants to replace missing teeth		50%	
Occlusal Guards		50%	

**When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's specified Nonparticipating Dentist Fee that will be paid for those services. This Nonparticipating Dentist Fee will likely be less than the fee charged by your dentist, and you will be responsible for the difference.*

- The maximum annual benefit is \$1,500 per covered individual.
- The annual deductible is \$50 per covered person/\$150 per covered family.
- The deductible does not apply to Class I covered services.
- Oral exams are payable twice per calendar year.

- Prophylaxes (cleanings) are payable twice per calendar year.
- Fluoride treatments are payable twice per calendar year for covered individuals up to age 19.
- Implants and implant-related services are payable once per tooth in any five-year period.
- Bitewing X-rays are payable once per calendar year and full mouth X-rays (which include bitewing X-rays) are payable once in any three-year period.
- Composite resin (white) restorations are optional treatment on posterior teeth. This means that the Plan will pay only the amount that it would have paid to restore the tooth with amalgam. You are responsible for the difference in cost.
- Porcelain crowns are optional treatment on posterior teeth. This means that the Plan will pay only the applicable amount that it would have paid for a full metal crown.
- There is no orthodontia coverage.

Your Quick Reference to Delta Dental

Delta Dental Customer Service
 (800) 524-0149
 8:30 a.m. – 7:50 p.m. ET
 Monday – Friday
www.deltadentaloh.com

When and How to Contact PNNL

Life Events and Changing Your Coverage

Under plan provisions, certain life events and actions trigger the requirement for you to notify PNNL and make a change to your level of coverage. Although there are no life events which allow you to increase your level of coverage, some events will require you to reduce your level of coverage or terminate your coverage altogether. These life events and actions, as listed below, should be reported to the Benefits Office as soon as possible.

If you have already experienced one of these life events or other actions and have not contacted the Benefits Office, please do so immediately.

Life Events and Other Actions

- Marriage, if you are a surviving spouse
- Divorce
- Death of a covered dependent
- Dependent no longer meets eligibility criteria
- Become Medicare eligible prior to age 65
- Enroll in a Medicare Part D plan

You have the right to reduce or cancel your medical and/or dental coverage at any time. Requests to change coverage or level of coverage for Medical or Dental must be received in writing by the 7th day of the month prior to the month you wish the change to be effective (e.g., request for changes to be effective May 1 must be received by Benefits no later than April 7).

If you drop coverage for yourself or a dependent, eligibility is forfeited and you may only re-enroll if you enroll and maintain coverage in a Medicare HMO after completing the Election to Terminate Battelle Retiree Medical Coverage form, available from the Benefits Office. You may then re-enroll at a later date for the following reasons:

- **One-time free election, no reason needed**
- **During an Open Enrollment Period**
- **Anytime there is an involuntary loss of coverage under the Medicare HMO, provided application is made within 31 days of such loss of coverage. If application is made within 31 days, coverage will be effective as of the first of the month following the loss of coverage.**

Please note that this exception applies to the retiree and spouse only and that dependent children cannot be re-enrolled.

Who to Contact:

PNNL Benefits Office
Pacific Northwest National Laboratory
902 Battelle Boulevard
P.O. Box 999, MS K1-34
Richland, WA 99352
Phone: (509) 375-6361
Fax: (509) 375-4455
<http://benefits.pnnl.gov/retirees.stm>
ask.benefits@pnnl.gov

Change of Address

Please call the Benefits Office for a Change of Address Request Form. The form is available online at <http://benefits.pnnl.gov/retirees.stm>. Complete and return it to the address listed on the form.

Pension Checks/Direct Deposit

Do you want to change your tax withholding or your direct deposit information? Do you need to report non-delivery of a pension check after a 3-4 day allowance for mail delay? Please call:

Barb Ferguson
Benefits Finance
614-424-6172
M-F, 7 a.m. – 4 p.m. EST
fergusonb@battelle.org

Direct Payment of Medical/Dental Premiums

Do you mail your medical and/or dental premiums to PayFlex? If you have questions, please call PayFlex at 800-284-4885 between 8 am and 7 pm Central, or check [www. HealthHub.com](http://www.HealthHub.com).

PayFlex Systems USA, Inc.
P.O. Box 2239
Omaha, NE 68103-2239

Your 2012 coupons will be mailed in December.

Other PNNL-Related Contacts

PNNL Retiree Network

The Retiree Network is dedicated to bringing together retired staff for further education and continued community. The Retiree Network meets every other month for a luncheon generally on the last Thursday of the month.

If you are interested in finding out more about the Retiree Network or would like to be added to their mailing list, please contact:

Bernie Saffell bernie4109@yahoo.com
Merry Valdez merrynvaldez@charter.net

Resources

Contact information for claims administrators is provided throughout this document and repeated below. Other useful contact information is provided for your convenience.

Anthem (Medical Plan)

Customer Service: (800) 514-3021
Anthem 24-Hour Nurse Line: (888) 596-9473
www.anthem.com

Anthem Blue View Vision (Vision Plan) – Non-Medicare Eligible Retirees Only

Customer Service: (866) 723-0515
www.anthem.com

CVS Caremark (Prescription Drug Benefits)

PNNL-dedicated Customer Service Toll-free Line: (877) 668-8993
www.caremark.com
www.caremark.com/battelle

Delta Dental (Dental Plan)

Customer Service: (800) 524-0149

www.deltadentaloh.com

Claims Only Mailing Address: PO Box 9085, Farmington Hills, MI 48333-9085

Written Inquiries Mailing Address: PO 9089, Farmington Hills, MI 48333-9089

Social Security Administration/Medicare

Social Security Administration Customer Service: (800) 772-1213

www.ssa.gov

Medicare Customer Service: (800) 633-4227

www.medicare.gov

Unum (Retiree Life Insurance)

Customer Service: (866) 269-0978

Unum (LTD Claim Contact, If Applicable)

Customer Service: (800) 858-6843

Vanguard

Battelle Employees' Savings Plan

Plan Number 092024

Phone: (800) 523-1188

- Call Vanguard's 24-hour automated VOICE Network to conduct transactions, get detailed information, and more. You'll need your personal identification number (PIN) to use the voice automated system. If you do not have a PIN, call the same number and speak with a Vanguard Participant Services Associate (see the following bullet).
- Call and speak with a Vanguard Participant Services Associate to get answers to your questions or help with transactions Monday through Friday from 8:30 a.m. to 9 p.m. Eastern time, or 5:30 a.m. to 6 p.m., Pacific Time
- Go to <http://battelle.vanguard-education.com>. This website provides information specifically related to the Battelle Employees' Savings Plan. In addition, it can help you manage your account, research your investment options, or learn how to maximize your savings.
- When you log on to www.vanguard.com, you can check your account balance, conduct transactions, research funds, and use financial planning tools. If you haven't registered for online access, you'll need your Plan number (092024).

Glossary of Key Benefits Terms

There are many key terms regarding your benefits mentioned throughout this guide. Please refer to this glossary, should you need clarification of a term to better understand your coverage.

Claims Administrator – The insurance organization with whom Battelle has contracted to process claims in accordance with the provision of Battelle’s self-insured plans. For example, Anthem is the claims administrator for the medical plans.

Co-insurance – A form of medical cost sharing that requires a covered person to pay a stated percentage of medical expenses after the deductible amount, if any, is paid.

Co-payment or Co-pay – A form of medical cost sharing that requires a covered person to pay a fixed dollar amount when a medical service is received.

Deductible – A fixed dollar amount that must be paid before the plan pays certain medical and dental benefits.

Formulary Drugs – A drug formulary is a list of prescription drugs that are preferred by your health plan. The list can include both generic and brand-name drugs that have been approved by the US Food and Drug Administration (FDA). When a drug is listed by your health plan, it may be referred to as a “formulary drug” because it is found on the formulary list.

Generic Drugs – Once a brand-name medicine’s patent expires, a generic version of the same drug, containing the same active ingredients, can be made and sold. Generic drugs must meet the same quality and safety standards as their brand-name counterparts. Using generic drugs usually costs less.

Network or Network Provider – A group of doctors, hospitals, or other health care providers who have contracted with a claims administrator (for example, Anthem) to provide services to covered members for less than their usual fees. Using network providers usually costs less.

Network Only Plan – A type of medical plan in which the claims administrator (for example, Anthem) has contracted with physicians or health care organizations within a network. You must use a network provider in order to receive coverage. There is no coverage for non-network services except in the case of an emergency.

Non-Formulary Drugs – A drug formulary is a list of prescription drugs that are preferred by your health plan. When a drug is not listed by your health plan, it may be referred to as a “non-formulary drug” because it is not found on the formulary list. Non-formulary drugs usually cost more and may not be covered or only partially covered by your plan.

Non-Network or Out-of-Network Provider – Physicians, hospitals, or other health care providers who have not contracted with a claims administrator (for example, Anthem) to provide services at a discount. Expenses incurred for services provided by non-network providers are not covered.

Out-of-Pocket Maximum – The most you pay each year in deductibles, co-insurance, co-pays, and other expenses. After you reach the out-of-pocket maximum, the plan pays 100 percent of eligible expenses for the remainder of the year.

Over-the-Counter (OTC) Drugs – Medicine that can be purchased from a pharmacy or store without a doctor's prescription.

Percent Co-insurance: The percent amount of the total cost of the prescription that you are responsible to pay. The dollar amount will vary depending on the cost of the items.

Preferred Provider Organization (PPO) Plan – A type of health or dental plan in which the claims administrator (for example, Delta Dental of Ohio) has contracted with providers within a network. You may choose to work with any of the providers within this network with higher coverage from the plan, or you may choose to work with a provider outside of the network in which you receive less coverage and bear more expense.

Prescription – A written or electronic order for a medicine or drug that meets the legal requirements of a prescription in the state in which the medical expense is incurred and that is issued by an individual who is legally authorized to issue a prescription in that state.

Prescription Drugs – Medicine that requires a doctor's prescription in order to be filled by the pharmacy.

Tier – The level of coverage that you choose as most-suitable for you and your family.